

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12192

CERTIFICATE OF DEATH

12203

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Calvert</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Calvert</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Prince Frederick</b>		c. LENGTH OF STAY IN lb <b>2 hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Lusby</b>		d. STREET ADDRESS —		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Calvert County Hospital</b>				e. 15 RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Annie Virginia Barrett</b>		First	Middle	Last	4. DATE OF DEATH <b>9</b>	Month	Day	Year
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-27-89</b>	9. AGE (In years last birthday) <b>77</b>	IF UNDER 1 YEAR Months <b>77</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours Min. <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Richard Allen</b>				14. MOTHER'S MAIDEN NAME <b>Sarah McCready</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-32-1252</b>		17. INFORMANT <b>Daniel Barrett</b>		Address <b>Lusby, Maryland</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b>		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause { <b>Cerebral Hemorrhage</b>		DUE TO (b) <b>Cerebral</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>52 Leonard, MD</b>		(County) (State)
21. Identify that (I) (this hospital) attended the deceased from <b>Oct. 17, 1967</b> , to <b>Sept. 20, 1967</b> , that (I) (we) last saw the deceased alive on <b>Sept. 20, 1967</b> and that death occurred at <b>1220 1/2 Leonard</b> , from causes and on the date stated above								
22a. SIGNATURE <b>D. Bellance</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>9-20-67</b>
22c. PHYSICIAN'S NAME (Type) <b>R. Bellance</b>		22d. ADDRESS <b>52 Leonard, MD</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Rural</b>		23b. DATE THEREOF <b>Sept. 27, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>St. Paul's Methodist Cemetery - Lusby, Calvert, Md.</b>		23d. LOCATION (City or Town) <b>52 Leonard, MD</b>		(County) (State)
24. FUNERAL DIRECTOR <b>Matthews &amp; Son, Inc., Rockville, Md.</b>		ADDRESS <b>10000 Rockville Pike, Box 354</b>		25d. RECD. BY REGISTRAR <b>Charles Judge</b>		25e. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>SEP 25 1967</b>



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove report papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2  
1  
12193  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12204

1. PLACE OF DEATH a. COUNTY Calvert			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Huntingtown			c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Huntingtown		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS 04-1		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Frances	Middle B.	Last Brooks	4. DATE OF DEATH 9 30 19 67
5. SEX F		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-12-82	9. AGE (in years last birthday) 85 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Mary Boone		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 212-56-0788		17. INFORMANT Mattie Kyler Huntingtown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X		INTERVAL BETWEEN ONSET AND DEATH Hypertension C.V. Disease			
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)					
DUE TO					
DUE TO					
DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)					
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 10	20f. (City or town) Huntingtown	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/24/67 to 9/30/67, that (I) (we) last saw the deceased alive on 9/24/67, and that death occurred at 1:30 A.M. from the causes and on the date stated above.		22b. DATE SIGNED 10/1/67			
22a. SIGNATURE J. W. Sewell		22b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) 10-4-67		23b. DATE THEREOF Bethel Way Of Cross		23d. LOCATION (City, town or county) Huntingtown - Md.	
24. FUNERAL DIRECTOR Pinkney E. Sewell		ADDRESS Prince Frederick		25a. REC'D BY REGISTRAR OCT 6 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge	



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12205

12194

## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-tranit Permit. Then please remove carbon papers. Pages and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Calvert</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Prince Frederick</b>		c. LENGTH OF STAY IN lb <b>139 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Prince Frederick</b>		d. STREET ADDRESS <b>—</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Calvert County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Margaret Jane</b>		First <b>Margaret</b>	Middle <b>Jane</b>
4. DATE OF DEATH <b>9 22 1967</b>		Last <b>Buckler</b>	Month Day Year
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>9-12-84</b>		9. AGE (In years last birthday) <b>83 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Edward Bowen</b>		14. MOTHER'S MAIDEN NAME <b>Agnes V. Buckler</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-36-6680</b>	
17. INFORMANT <b>Agnes Buckler</b>		Address <b>Prince Frederick, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442X</b> DUE TO <b>Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Hypertension C.V. heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
(b) <b>442X</b> DUE TO <b>Hypertension C.V. heart disease</b>		4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>Home</b>
20f. (City or town) <b>Prince Frederick</b>		(County) <b>Calvert</b>	
(State) <b>Md.</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 6, 1967</b> , to <b>Sept 22, 1967</b> , that (I) (we) last saw the deceased alive on <b>Sept. 22 1967</b> , and that death occurred at <b>3101</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Page C Jett</b>		22b. DATE SIGNED <b>9-22-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Page C Jett</b>		22d. ADDRESS <b>PRINCE FREDERICK</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Sept 25, 1967</b>		23b. DATE THEREOF <b>Central Cemetery</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Central Cemetery</b>
24. FUNERAL DIRECTOR <b>A.O. Harkness &amp; Son, Port Republic, Md.</b>		25a. ADDRESS <b>McGill, Port Republic, Md.</b>	25b. REC'D BY REGISTRAR <b>Charles Judge</b>
		DATE <b>SEP 26 1967</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**12195**

**CERTIFICATE OF DEATH**

**12206**

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Calvert</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince Frederick, Md.</b> 15 hrs.		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Barstow</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Calvert County Hospital</b>		d. STREET ADDRESS —	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Luster</b>		First <b>Lee</b>	Middle <b>Carson</b>
3. NAME OF DECEASED (Type or print) <b>Luster</b>		Last <b>Carson</b>	4. DATE OF DEATH <b>September 16 1967</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. B. DATE OF BIRTH <b>5-22-85</b>		9. AGE (In years (last birthday) <b>82</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>B. W. Lowe</b>		14. MOTHER'S MAIDEN NAME <b>Georgia Ann</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>242-22-7072</b>	
17. INFORMANT <b>Ruby Noland, Barstow, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (last) <b>C. V. A.</b>		INTERVAL BETWEEN ONSET AND DEATH	
b) DUE TO c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Barstow, Calvert, Md.</b>
20f. (City or town) <b>Barstow, Calvert, Md.</b> (County) <b>Calvert</b> (State) <b>Md.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>1966</b> , 19, to <b>9-19-67</b> , 19, that (I) (we) last saw the deceased alive on <b>9-19-67</b> , 19, and that death occurred at <b>Barstow, Calvert, Md.</b> from causes and on the date stated above.		22b. DATE SIGNED <b>Prince Frederick, Md.</b>	
22a. SIGNATURE <b>Issam El Damalouji, M.D.</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>Prince Frederick, Md.</b>
22c. PHYSICIAN'S NAME (Type) <b>Issam El Damalouji, M.D.</b>		22d. ADDRESS <b>Barstow, Calvert, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 19, 1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Southern Maryland Cemetery, Barstow, Calvert, Md.</b>
24. FUNERAL DIRECTOR <b>A.J. Harkness &amp; Son, Inc., Prince Frederick, Md.</b>		23d. LOCATION (City or Town) (County) (State) <b>Barstow, Calvert, Md.</b>	25a. REC'D BY REGISTRAR <b>Charles Judge</b>
		ADDRESS <b>Box 34</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>
		DATE <b>SEP 19 1967</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**12196**

**CERTIFICATE OF DEATH**

**12207**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove from both papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Calvert</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Prince Frederick</b>		c. LENGTH OF STAY IN lb <b>4 days 2½ hours</b> d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Huntingtown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Calvert County Hospital</b>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Charlotte</b>		First <b>Lottie</b>	Middle <b>Chase</b>
3. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>8-20-12</b>		9. AGE (In years lost birthday) <b>55 yrs.</b>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Isaac Freeland</b>		14. MOTHER'S MAIDEN NAME <b>Mamie Chew</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Cornelius Chase, Huntingtown, Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		Address <b>C. V. A - Hypertension</b>	
		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>Prince Frederick</b>		(County) (State) <b>Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>9-10-67</b> , 19 <b>67</b> , to <b>9-14</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>9-14</b> , 19 <b>67</b> , and that death occurred <b>6:30PM</b> , from causes and on the date stated above			
22a. SIGNATURE <i>Osman Z. Ersoy</i>		22b. DATE SIGNED <b>9-15-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Osman Z. Ersoy, M.D.</b>		22d. ADDRESS <b>Prince Frederick, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9-17-67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Patuxent Church Cem.</b>
24. FUNERAL DIRECTOR <b>Leroy E. Berry - Huntingtown, Md.</b>		ADDRESS	25a. RECD BY REGISTRAR <b>Charles Judge</b>
			25b. REGISTRAR'S SIGNATURE <b>SEP 19 1867</b>

medicinal, social, and economic

## MARYLAND STATE DEPARTMENT OF HEALTH

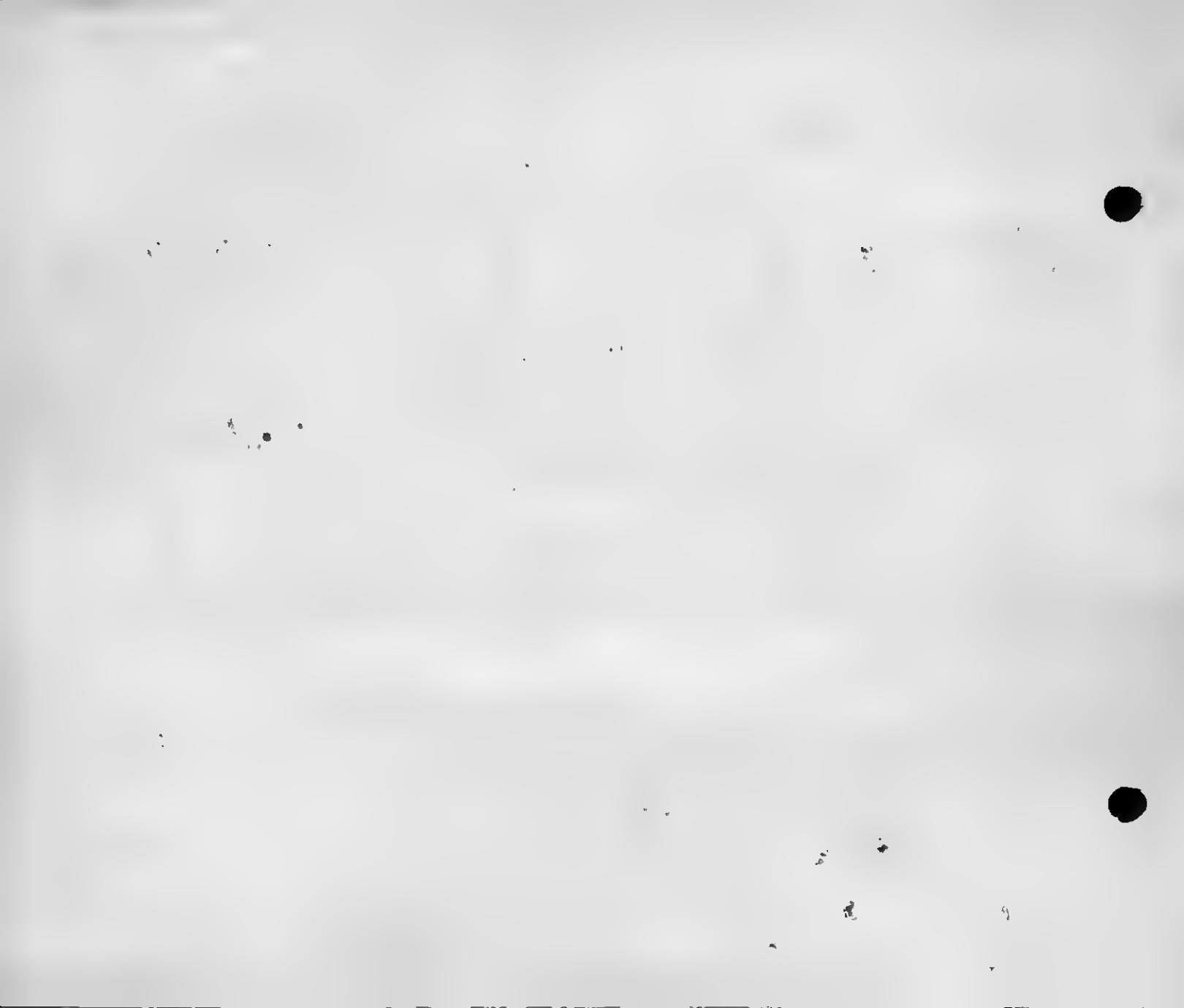
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
1219.

12208

## CERTIFICATE OF DEATH

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

PLACE OF DEATH a. COUNTY <b>CALVERT</b>		MARYLAND c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE <b>MARYLAND</b>		b. COUNTY <b>CALVERT</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL PRINCE FREDERICK</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CHESEPEAKE BEACH</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>OLD BAYSIDE ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>CALVERT COUNTY HOSPITAL</b>		First Middle		Last		4. DATE OF DEATH Month Day Year <b>SEPT 17 1967</b>	
3. NAME OF DECEASED (Type or print) <b>EDWARD ALBERT</b>		6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH Last (in years last birthday) <b>FEB 12, 1888 79 yrs.</b>		9. AGE (in years last birthday) 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TYPE WRITER MECHANIC</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>TYPE WRITERS, NEW YORK.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>UNKNOWN</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		10. KIND OF BUSINESS OR INDUSTRY <b>UNKNOWN</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give rank or date of service) <b>NO</b> 577-03-1945 BARBARA FAY KELLY 7113 BRIDAL PATH LANE HYATTSVILLE, MD		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Cerebral accident</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO (c)		Address INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1b) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> At work <input type="checkbox"/> At work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>1010 1/2 HUNTINGTON</b>	
						(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from ... 1967 to 1967, that (I) (we) last saw the deceased alive on ... 1967, and that death occurred at ... M, from the causes and on the date stated above.		22b. DATE SIGNED					
22e. SIGNATURE <b>GEORGE J. WEEMS</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) <b>GEORGE J. WEEMS</b>		22d. ADDRESS <b>Huntington</b>					
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <b>BURIAL 20 SEPT, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>CEDAR HILL CEM</b>		23d. LOCATION (City, town or county) <b>SUITLAND, MARYLAND</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. CHAMBERS Co., RIVERDALE, Md.</b>		ADDRESS <b>W.W. CHAMBERS Co., RIVERDALE, Md.</b>		25a. REC'D BY REGISTRAR DATE SEP 21 1967		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

12193

## **CERTIFICATE OF DEATH**

12209

1 PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)							
Calvert, Maryland		a. STATE Maryland b. COUNTY Calvert							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Prince Frederick		c. LENGTH OF STAY IN lb							
9 days		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dunkirk, Maryland							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print) Mary		First	Middle						
Female		6 COLOR OR RACE Negro	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 4-6-91	9. AGE (In years lost birthday) 76 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Frank Randall		14. MOTHER'S MAIDEN NAME unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 577-48-9250		17. INFORMANT Sarah Hawkins, Dunkirk, Maryland	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c) DUE TO PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)		19. INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. CITY OR TOWN (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/1/67</u> , 19 <u>67</u> , to <u>9/6</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>9/1/67</u> , 19 <u>67</u> , and that death occurred at <u>M</u> , from causes and on the date stated above		22a. SIGNATURE <u>Frank Randall</u>		22b. DATE SIGNED <u>9/6/67</u>					
22c. PHYSICIAN'S NAME (Type) R de VILLEARDEN		22d. ADDRESS <u>57 Leonard, Jr</u>							
23a. FUNERAL DIRECTOR P. L. De VILLEARDEN		23b. DATE THEREOF 9/21/67		23c. NAME OF CEMETERY OR CREMATORIAL MOses cem.		23d. LOCATION (City or Town) Prince Frederick, Md.		(County) (State)	
24. FUNERAL DIRECTOR P. L. De VILLEARDEN		25a. ADDRESS Prince Frederick, Md.		25b. REC'D BY REGISTRAR SEP 20 1967		25c. REGISTRAR'S SIGNATURE Charles Judge			

**HOSPITAL OR ATTENDING PHYSICIAN.** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

VR A15 (4)  
25M 1/63

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that Page 4 may be retained by the hospital or attending physician.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial or transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

VR A15 (4)  
25M 1/63



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12210

12193

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Calvert</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Prince Frederick</b>		c. LENGTH OF STAY IN 1b <b>55 minutes</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Calvert County Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Chesapeake Beach</b>	
3. NAME OF DECEASED (Type or print) <b>Francis</b> First <b>Matthew</b> Middle <b>Hines</b> Last		4. DATE OF DEATH 9 15 1967	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED WIDOWED		8. NEVER MARRIED DIVORCED	
9. DATE OF BIRTH <b>4-18-1900</b>		10. AGE (in years last birthday) <b>67 yrs</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Police</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Amusement Park</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Francis Hines</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Woods</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) <b>Yes W.W.I</b>		16. SOCIAL SECURITY NO <b>578 05 8525</b>	
17. INFORMANT <b>Mrs Margaret Hines Same as 2</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>42.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Coronary Occlusion</b> DUE TO DUE TO (c) <b>the heart disease is in full swing</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 16, 1967</b> to <b>Sept 17, 1967</b> , that (I) (we) last saw the deceased alive on <b>Sept 15, 1967</b> , and that death occurred at <b>2 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Page C. Jett, M.D.</b>		22b. DATE SIGNED <b>9/16/67</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>Prince Frederick, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept 16, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORIUM <b>Mt Harmony Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Owings Calvert Md</b>	
24. FUNERAL DIRECTOR <b>Dutchman Funeral Home Owings, Md.</b>		25a. ADDRESS <b>Owings, Calvert Md</b>	
25b. REC'D BY REGISTRAR <b>Charles Jett</b>		25c. REGISTRAR'S SIGNATURE <b>Charles Jett</b>	
DATE <b>SEP 19 1967</b>		DATE <b>SEP 19 1967</b>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

Death if any delay is  
Pages 1, 2, and 3 to  
with form PM3 Page

**LEGAL EXAMINER:** This certificate should be executed within 24 hours of the time of death. Execute the certifcate, writing the word "Pending" in pencil in Item 18. Give to the Coroner. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the certificate. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the deceased agent, prior to burial, cremation, or removal, and in any event with the deceased agent.

**TO DEPUTY MEDICAL EXAMINER**  
necessary, please  
the funeral director  
may be retained  
**TO FUNERAL DIRECTOR**  
Health or its designee

VR A15ME (6)  
AM 1/6

12200

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1821

1 PLACE OF DEATH b COUNTY		2 USUAL RESIDENCE (Where deceased resided, if institution Residence before admission)	
Breezy Point, Chesapeake Bay, Maryland		b STATE	
b CITY OR TOWN (If outside corporate limits, give RURAL and g ve nearest town)		CITY OR TOWN (If outside corporate limits, give RURAL and g ve nearest town)	
Breezy Point		Chesapeake Bay, Ocean Beach, Breezy Point	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d STREET ADDRESS	
Hutchins Funeral Home, Ocean Beach, Breezy Point		141	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)		First Midd. Last	
James Malcolm Jett		4 DATE OF DEATH	
S SEX		Month Day Year	
M		9 18 1967	
6 COLOR OR RACE		5 LENGTH OF STAY IN b	
White		1 to 10 days	
7 MARRIED		8 DATE OF BIRTH	
Married		8/15/01	
WIDOWED		9 AGE (In years at time of death)	
Divorced		66 yrs	
10a. USUAL OCCUPATION (If not in hospital, give street address)		11 BIRTHPLACE (State or foreign country)	
Self-employed Retired		Va.	
d The most of work in life, even if retired)		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME		14 MOTHER'S Maiden NAME	
Frank Jett		Jenny Franklin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16 SOCIAL SECURITY NO	
No		—	
17 INFORMANT		Address	
Mrs. Charlotte Jett, Same as 2			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))		INTERVAL BETWEEN DEATH AND DEATH	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) — DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		30 days	
(b) — DUE TO Age			
(c) —			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day, Year Hour p.m. 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm factory, street, off ce bldg, etc.)		20f. (City or town) (County) (State)	
Hutchins Funeral Home, Breezy Point, Maryland		Clinton, DeSoto, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
H. W. WARD		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMAINS (Specify)		23b. DATE THEREOF	
Burial		Sept 21, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town) (County) (State)	
Resurrection Cemetery		Clinton, DeSoto, Md.	
24. FUNERAL DIRECTOR		25a. REC'D. BY REGISTRAR	
Hutchins Funeral Home, Ocean Beach, Breezy Point		25b. REGISTRAR'S SIGNATURE	
ADDRESS		SEP 21 1967	
Hutchins Funeral Home, Ocean Beach, Breezy Point		Signature	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12201

CERTIFICATE OF DEATH

12212

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Calvert</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Prince Frederick</b>		c. LENGTH OF STAY IN 1b <b>43 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Calvert County Hospital</b>		e. STREET ADDRESS <b>North Beach</b>	
3. NAME OF DECEASED (Type or print) <b>Mary</b>		4. DATE OF DEATH <b>9 29 1967</b>	Month Day Year
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-24-02</b>
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (in years last birthday) <b>65 yrs.</b>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>District of Columbia</b>	
13. FATHER'S NAME <b>Guy M. Roby</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Conden</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>217-03-8320</b>	
17. INFORMANT <b>James W. Lea, Jr.</b>		18. INFORMANT <b>Prince Frederick</b>	
19. MEDICAL CERTIFICATION		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 1, 1964</b> to <b>Sept. 29, 1967</b> , that (I) (we) last saw the deceased alive on <b>9/1/67</b> , and that death occurred at <b>12:30 PM</b> , from causes and on the date stated above		20f. (City or town) <b>Prince Frederick</b> (County) <b>Maryland</b> (State)	
22a. SIGNATURE <i>Osman Z. Ersoy</i>		MD <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <b>Osman Z. Ersoy, M.D.</b>		22d. ADDRESS <b>Prince Frederick, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL 10-3-1967</b>		23b. DATE THEREOF <b>10-3-1967</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Rock Creek</b>
24. FUNERAL DIRECTOR <b>HANLON FUNERAL HOME - Wash. D.C.</b>		23d. LOCATION (City or Town) (County) (State) <b>Wash. D.C.</b>	
ADDRESS		25a. REC'D BY REGISTRAR DATE <b>OCT 5 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



1  
2 FOR STATE  
HEALTH DEPT.

3  
4 necessary. Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to  
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form  
PM3 Page 5 may be retained for your files.

5 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of  
Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12202

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12213

1 PLACE OF DEATH a COUNTY <b>CALVERT</b>			2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE <b>Md.</b>		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PRINCE FREDERICK</b>			c LENGTH OF STAY IN 1b <b>5 days</b>		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Calvert Co. Hospital</b>			e CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE, Md.</b>		
f STREET ADDRESS <b>6007 Hunt Ridge Rd.</b>			g IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) <b>First</b> <b>VIRGINIA</b> <b>Middle</b> <b>C.</b>		4 DATE OF DEATH <b>MERRITT</b> <b>Month</b> <b>9</b> <b>Day</b> <b>6</b> <b>Year</b> <b>1967</b>			
5 SEX <b>F</b>	6 COLOR OR RACE <b>W</b>	7 MARRIED WIDOWED <input type="checkbox"/>	8 NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	B DATE OF BIRTH <b>2/5/1882</b>	9 AGE (In years last birthday) <b>75</b> yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10b KIND OF BUSINESS OR INDUSTRY <b>H.W.</b>		
11 BIRTHPLACE (State or foreign country) <b>Md.</b>			12 CITIZEN OF WHAT COUNTRY?		
13 FATHER'S NAME <b>Charles S. MERRITT</b>			14 MOTHER'S MAIDEN NAME <b>VIRGINIA CARR</b>		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? <b>NO</b> (Yes, no, or unknown) (If yes give war or dates of service)			16 SOCIAL SECURITY NO 17 INFORMANT <b>Hospital Chart</b> Address		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Paralysis of entire body</b> INTERVAL BETWEEN ONSET AND DEATH					
DUE TO (b) <b>Injured Neck</b>					
DUE TO (c) <b>Automobile Accident</b> <b>5 days</b>					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Auto Accident</b> <b>DECEASED @ 12:30 AM 9/6/67</b>					
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 1b) <b>at intersection of road under construction</b>					
20c TIME OF INJURY Month, Day, Year Hour <b>0</b> min <b>0</b> sec <b>11:30</b> <b>pm</b> <b>9/1</b> <b>1967</b>					
20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>					
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Road</b> <b>Sunderland Calvert Md.</b>					
20f (City or town) (County) (State)					
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>H.W. Ward</b> MD					
EXAMINER'S NAME (Type) <b>Hugh W. WARD, M.D.</b>					
22. DATE SIGNED <b>9/6/67</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>9-8-67</b>		23c. NAME OF CEMETERY OR CEMATORIAL <b>LOUDON PARK Cem.</b>	
23d. LOCATION (City or Town) <b>BALTO. MD.</b>				(County) (State)	
24. FUNERAL DIRECTOR ADDRESS		25a. REC'D BY REGISTRAR DATE <b>SEP 11 1967</b>		25b. REGISTRAR'S SIGNATURE <b>John Burns Sons Towson</b>	
VR AT5ME 6 6M 1/64					



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Boxes 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Box 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent prior to burial, cremation, or removal, and in any event within 24 hours after death.

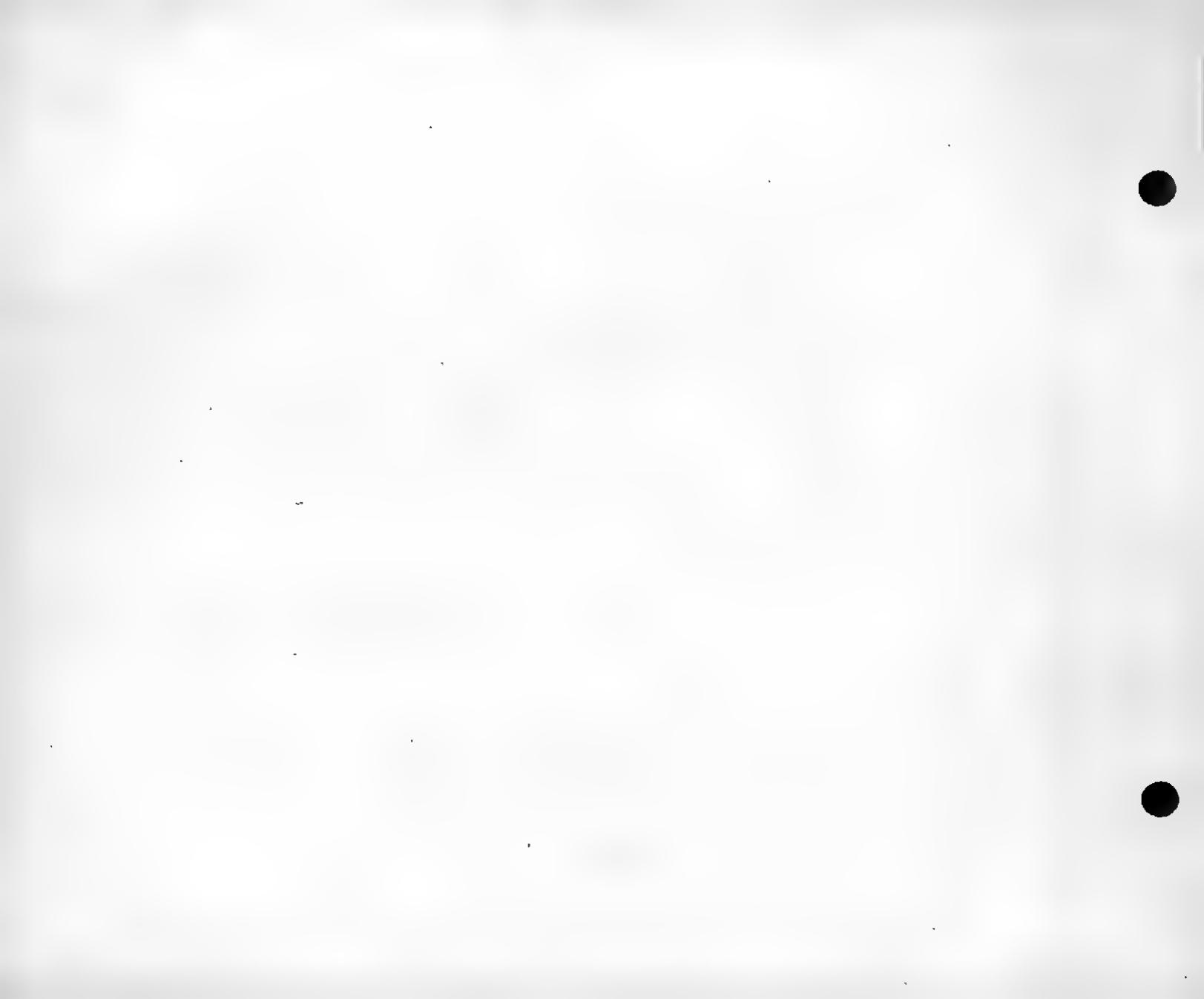
12203

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12214

1 PLACE OF DEATH a COUNTY		2 USUAL RESIDENCE (Where deceased lived, 1 institution, Residence before admission)	
b CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)		d STATE	
c CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)		e COUNTIES	
d STREET ADDRESS		f IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print)		4 DATE OF DEATH Month 9 Day 38 Year 1967	
5 SEX M		6 COLOR OR RACE W	
7 MARRIED WIDOWED		8 NEVER MARRIED DIVORCED	
9a DATE OF BIRTH Jan. 25, 1952		9b AGE (in years last birthday) 12 yrs	
10a. KIND OF BUSINESS OR INDUSTRY Student		11. BIRTHPLACE (State or foreign country) Calvert County, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John (Hooper) Minter	
14. MOTHER'S M AIDEN NAME Somel Hopper (step-father) Prince		15. WAS DECEASED EVER IN U.S. ARMED FORCES? No	
16. SOCIAL SECURITY NO none		17. INFORMANT Somel Hopper (step-father) Prince	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO 813.4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH In acquired chronic lung disease left Auto accident	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Two on bicycle pulled across in front of car car hit road side of bicycle		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month Day Year Hour min. 54 p.m. 54 p.m. 9 30 67		20d. PLACE OF INJURY (Home, farm, factory, street, office, etc.) Highway	
20e. (City or town) Baltimore		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 9/30/67	
ACTUAL SIGNATURE H W Ward EXAMINER'S NAME (Type) H W Ward - Calvert Co.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, Cremation REMOVAL (Specify) Burial Oct. 4, 1967		23b. DATE THEREOF Oct. 4, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS G. P. Arbuckle & Son, Port Republic, Md.		23d. LOCATION (City or Town) Calvert Co., Md.	
24. FUNERAL DIRECTOR ADDRESS G. P. Arbuckle & Son, Port Republic, Md.		25a. RECD BY REGISTRAR OCT. 3 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



12215

## CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>Calvert</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince Frederick</b>		c. LENGTH OF STAY IN 1b <b>14 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince Frederick</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Calvert County Hospital</b>			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) <b>Samuel Washington Murray</b>		First <b>Samuel</b>	Middle <b>Washington</b>	Lost <b>0</b>	4. DATE OF DEATH <b>September 9 1967</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEP. DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>2-11-05</b>	9. AGE (In years last birthday) <b>62</b> yrs	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>
11b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Edward Murray</b>			14. MOTHER'S MAIDEN NAME <b>Maggie Sanders</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>217-12-8845</b>		17. INFORMANT <b>Medical records chart</b>	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Dehydration</b> INTERVAL BETWEEN ONSET AND DEATH DUE TO <b>Diarrhoea</b> <b>3 hrs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Ch. J. E. 50 pharynx</b> DUE TO <b>Diarrhoea</b> (c) <b>Diarrhoea</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	20f. (City or town) <b>St. Leonards</b>	(County) <b>Maryland</b> (State)
21. I certify that (1) (this hospital) attended the deceased from <b>1967</b> , to <b>1967</b> , that (1) (we) last saw the deceased alive on <b>1967</b> and that death occurred at <b>M</b> , from causes and on the date stated above					
22a. SIGNATURE <b>Roberto de Villarreal</b>		22b. DATE SIGNED <b>1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>Roberto de Villarreal, M.D.</b>		22d. ADDRESS <b>St. Leonards, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Brook Ch.Cem</b>		23b. DATE THEREOF <b>9 13-67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Brook Ch.Cem</b>	23d. LOCATION (City or Town) <b>Mutual</b>	(County) <b>Cal</b> (State) <b>Md</b>
24. FUNERAL DIRECTOR <b>Penkney E. Seewell, funeral Director, Inc.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>SEP 13 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

certificate be executed within 24 hours after death.

**ATTENDING PHYSICIAN:** The law requires that a physician be retained by the hospital or attending physician.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and page 3, within 72 hours after death.

VR A15  
25M 1/6

Finkney & Sorell, Funeral Directors,

250. REC'D BY REGISTRAR

DATE SEP 13 1967

25b. REGISTRAR'S SIGNATURE

7 Charles Duse



1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12205 CERTIFICATE OF DEATH 12206											
Item #9 Film #G193 9725707 ph											
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY									
Calvert MARYLAND		Maryland Calvert									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b									
Rural-Prince Frederick		4 days									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Rural- Chesapeake Beach									
Calvert County Hospital		d. STREET ADDRESS									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month Day Year	
female		Alverta		Brown		Sewell		9		13 19 67	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS.	
negro		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		3-26-03		63 51 yrs.		Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Farm Labor				Maryland		U.S.A.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
Benjamin Brown		Rosie Brooks									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
(If yes give war or dates of service)		213-38-4326		Marthalene Holland		Sunderland, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral</i> <i>collapse</i>											
DUE TO (b) <i>Cerebral</i> <i>collapse</i> <i>of</i> <i>liver</i>											
DUE TO (c) <i>Cerebral</i> <i>collapse</i> <i>of</i> <i>liver</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
19											
21. I certify that (I) (this hospital) attended the deceased from Sept. 9, 1967, to Sept. 13 19 67 that (I) (we) last saw the deceased alive on Sept. 13 19 67, and that death occurred at 2:15 PM, from the causes and on the date stated above.											
22a. SIGNATURE <i>Osman Z. Ersoy</i>											
22b. DATE SIGNED 9-13-67											
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS									
Osman Z. Ersoy		Prince Frederick, Maryland									
23a. BURIAL/CREMATION/REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIY		23d. LOCATION (City, town or county)		(State)			
9-15-67		St. Edmonds Cem.		Calvert Co. Md.							
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Pinkney E. Sewell Prince Frederick		DATE SEP 20 1967		Charles J. Judge							
10/10/67											
VR A15 (4) 15M 4-64											

212-83-4256

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

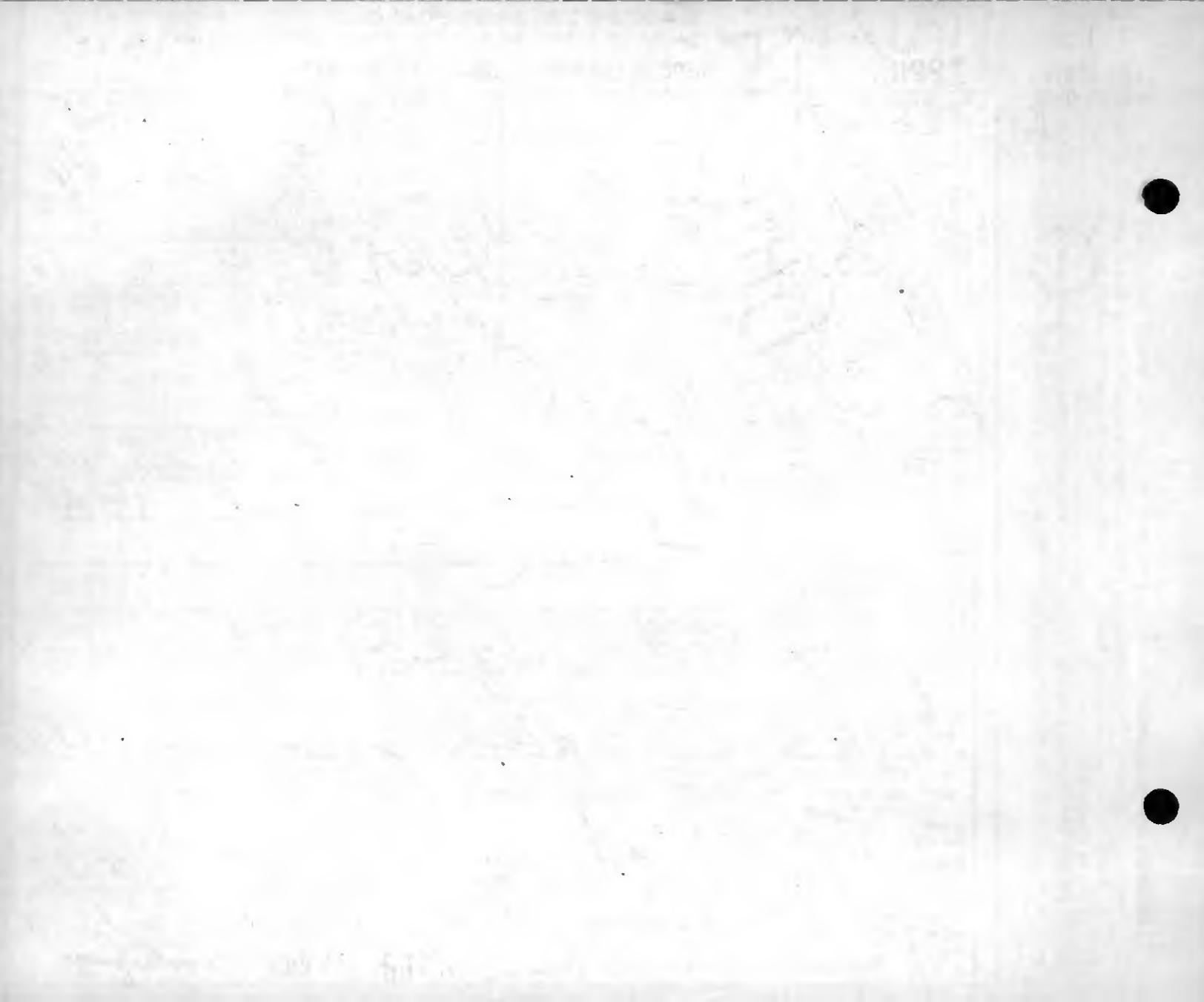
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the notes. Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

12206

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. LENGTH OF STAY IN 1b d.o.a.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Calvary</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>	
3. NAME OF DECEASED (Type or print) <i>James</i>		First <i>W</i>	Middle <i>Orville</i>
4. DATE OF DEATH <i>Dec. 17, 1953</i>		Last <i>13</i>	Month <i>9</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED NEVER MARRIED WIDOWED DIVORCED <i>W</i>
8. DATE OF BIRTH <i>Dec. 17, 1953</i>		9. AGE (In years as of birthday) <i>13</i>	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>School</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Student</i>	11. BIRTHPLACE (State or foreign country) <i>Calvert County, Md.</i>
13. FATHER'S NAME <i>James Orville Shufflett</i>		14. MOTHER'S MAIDEN NAME <i>Eleanor Meister</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT <i>Mary Shufflett - Prince Frederick, Md.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <i>813.4</i>		INTERVAL BETWEEN INJURY AND DEATH <i>20 days</i>	
IMMEDIATE CAUSE (a) DUE TO <i>Fractured skull and</i> (b) DUE TO <i>at leg (left)</i> (c)			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. <i>Fractured skull and</i> <i>at leg (left)</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Blunt weight pulled across leg</i>	
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> p.m. <i>5:45 p.m.</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Calvert County, Md.</i>
21. I certify that I took charge of the remains described above, Held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <i>9/30/67</i>	
ACTUAL SIGNATURE <i>H. W. Ward</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>H. W. Ward, Calvert Co.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Oct. 4, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Abury Cemetery</i>
24. FUNERAL DIRECTOR <i>O. A. Harkness &amp; Son, Port Republic, Md.</i>		23d. LOCATION (City or Town) (County) (State) <i>Barstow Calvert, Md.</i>	
ADDRESS		24a. RECD BY REGISTRAR DATE <i>OCT 3 1967</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12218

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Calvert</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Prince Frederick</b> D.O.A.		c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Calvert County Hospital</b>	
3. NAME OF DECEASED (Type or print) <b>Rodger Milbourne Woolford, Sr.</b>		First	Middle
4. DATE OF DEATH 9 13 19 67		Last	Month
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <b>WIDOWED</b>		8. NEVER MARRIED <b>Divorced</b>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction-Mate</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Milbourne Woolford</b>		14. MOTHER'S MAIDEN NAME <b>Bertie Horseman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) <b>Yes</b> <b>World War II</b>		16. SOCIAL SECURITY NO. <b>217-16-7966</b>	
17. INFORMANT <b>Catherine P. Woolford</b>		Address <b>same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b>		Coronary Occlusion	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause if any (b)		Years <b>Years</b>	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-</b>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Prince Frederick</b> (County) <b>Maryland</b> (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 20</b> , 1964, to <b>9-13-67</b> , that (I) (we) last saw the deceased alive on <b>9-12-67</b> , and that death occurred at <b>5:15 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Page C. Jett</b>		22b. DATE SIGNED <b>9-13-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Page C. Jett, M.D.</b>		22d. ADDRESS <b>Prince Frederick, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 16, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Solomons Methodist Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Solomons, Calvert, Md.</b>	
24. FUNERAL DIRECTOR <b>AA Harkness &amp; Son - Port Republic, Md.</b>		25a. RECEIVED BY REGISTRAR ADDRESS <b>Bay 34</b> DATE <b>SEP 15 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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